sigvaris

COLLINS SURGICAL

First Name: _____ Last Name: _____ Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Cell Phone: _____ ❑ Male ❑ Female

Email: _____ Home Phone: _____

PCP Name: _____ Dr.'s Phone: _____

Dr.'s Location (Town or Facility): _____

COLLINS SURGICAL

14 Norfolk Ave
Easton, MA 02375
P: 508-580-2825
F: 508-586-3058

Insurance Information

❑ MGB HEALTH PLAN
❑ HPHC
❑ TUFTS
❑ BCBS
❑ FALLON
❑ MEDICARE
❑ MASS HEALTH
❑ UNITED
❑ SWH
❑ BMC
❑ TUFTS PP
❑ WC
❑ OTHER: _____

INSURANCE POLICY #: _____

Custom Measurements

Compression Level

❑ 15–20 mmHg
❑ 20–30 mmHg
❑ 30–40 mmHg

Compression Length

❑ Closed toe
❑ Open toe
❑ Calf
❑ Calf w/ grip top
❑ Thigh
❑ Pantyhose

Flow Tech

❑ Orchid
❑ Cool Grey
❑ Deep Sea
❑ Sage
❑ Teal
❑ Slate
❑ Sky Blue
❑ Black

Microfiber Patterns

❑ Mariner Stripe (W)
❑ Cranberry Chevron (W)
❑ Graphite Confetti
❑ Pink Stripe (W)
❑ Graphite Stripe (M)
❑ Onyx Stripe
❑ Grey Hearts (W)
❑ Navy Hearts (W)
❑ Graphite Heather
❑ Storm Blue Confetti (W)
❑ Black Plaid (M)
❑ Purple Argyle (W)
❑ Graphite Argyle
❑ Royal Blue Argyle
❑ Wisteria Windows (W)
❑ Graphite Chevron

Sea Island Cotton

❑ Navy ❑ Black

Dynaven

❑ Black
❑ Light Beige

Thermoregulating Wool

❑ Charcoal ❑ Olive

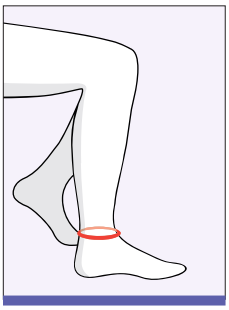
Linen

❑ Brown (M)
❑ Denim (W)
❑ Light Grey
❑ Lavender (W)
❑ Sandstone
❑ Eucalyptus

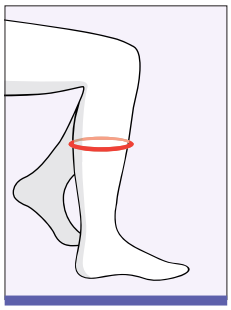
High Tech

❑ White
❑ Black
❑ Blue
❑ Lime
❑ Pink
❑ Red
❑ Steel Blue

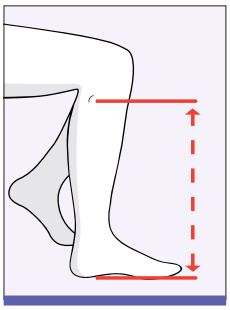
W= for Women only
M = for Men only



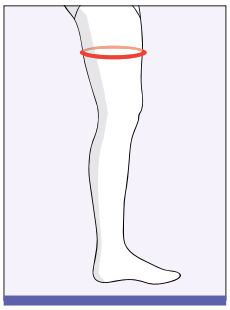
1. Measurement (B)
Ankle Circumference



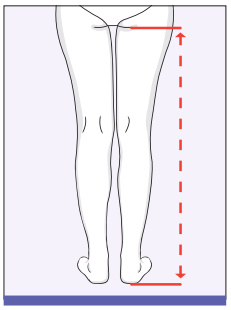
2. Measurement (C)
Calf Circumference



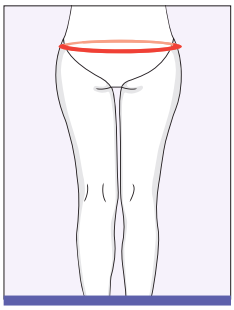
3. Measurement (A–D)
Calf Length



4. Measurement (G)
Thigh circumference at the widest area



5. Measurement (A–G)
Leg Length



6. Measurement (H*)
Hip circumference

Ankle Circ.	Calf Circ.	Calf Length	Thigh Circ.	Leg Length	Hip Circ.
L:_____	L:_____	L:_____	L:_____	L:_____	L:_____
R:_____	R:_____	R:_____	R:_____	R:_____	R:_____

*Measure point letter may very with inelastic garments, please reference the Sigvaris Catalog for a product specific point.

Shoe size:_____

Weight:_____

Live your life.
Be yourself.

SIGVARIS GROUP

sigvaris.com

LIT-COLLINSPAD 0425

COLLINS SURGICAL

RELEASE(S) AND/OR ACKNOWLEDGEMENT(S) TO COLLINS SURGICAL

Please have a patient initial and date each line; sign and date the bottom

I authorize payment of assigned medical benefits to be paid directly to Collins Surgical for services rendered towards my care by Collins Surgical. This authorization shall remain intact until rescinded by me in writing.

INITIALS: _____ DATE:_____

I authorize the release of all medical records pertaining to the supplies I am requesting from Collins Surgical to ensure I qualify for insurance benefits to be paid on my behalf. This authorization shall remain intact unless rescinded by me in writing.

INITIALS:_____ DATE:_____

My request for compression stockings is not related to a motor vehicle and/or a work related injury. Failure to disclose this information at the time of service will make me 100% responsible for payment, if the claim is denied by my primary healthcare insurance company.

INITIALS:_____ DATE:_____

I acknowledge that all compression garments remain property of Collins Surgical until purchased, either by myself or a third party (insurance company/private party). If my insurance company denies my claim, the denial will make me personally and legally responsible for payment in full.

INITIALS:_____ DATE:_____

I acknowledge Collins Surgical has made a personal copy of the “Medicare Suppliers Standards” and/or a copy of Collins Surgical “Patient Bill of Rights” available to the beneficiary.

INITIALS:_____ DATE:_____

I have been instructed and understand the use and function of the stockings provided to me by Collins Surgical.

INITIALS:_____ DATE:_____

I acknowledge I have never been diagnosed with, treated for or have knowledge of having: arterial insufficiency (ABI<0.5), intermittent claudication, ischemia, uncontrolled congestive heart failure, acute dermatitis, weeping dermatitis, cutaneous sepsis or any other local skin or soft tissue diseases.

INITIALS:_____ DATE:_____

_____

SIGNATURE DATE

_____

PRINT NAME